

**State Employee Benefits Committee
Tatnall Building, Room 112
Dover, Delaware 19904**

The State Employee Benefits Committee met January 23, 2017. The following people were in attendance:

Committee Members:

Mike Jackson, Director, OMB
Rick Geisenberger, Secretary of Finance
Bethany Hall-Long, Lt. Governor
Geoff Klopp, COAD
Jamie Mack, Designee of DHSS
Mike Morton, Controller General
Trinidad Navarro, Insurance Commissioner
Evelyn Nestlerode, Designee of Chief Justice, Administrator of Courts
Ken Simpler, Treasurer

Guests:

Brenda Lakeman, Director, SBO
Faith Rentz, Deputy Director, SBO
Lisa Porter, SBO
Joanna Adams, Pensions
Ginger Angstadt, DSEA-R
Jennifer Bredemeier, Univ of DE
Ronald Burrows, DRSPA
Karin Faulhaber, PHRST
Jacqueline Faulcon, DRSPA
Judy Grant, HMS
Darcell Griffith, Univ of DE

Guests (continued):

Leighann Hinkle, SBO
Chris Hudson, Univ of DE
Andrew Kerber, DOJ
Russell Larson, The Byrd Group
Melissa Marlin, OMB
Regina Mitchell, OMB
Casey Oravez, OMB, Financial Ops
Kimberly Reinagel-Nietubicz, CGO
Vincent Ryan, DOI
Jim Testerman, DESA-R
Valerie Watson, Finance

Sheri Sack, Aflac
Lauren Morhard, Aetna
Mike North, Aetna
Andrew Brancati, Highmark
Jennifer Mossman, Highmark
Pamela Price, Highmark
Walt Mateja, Truven Consulting
Kevin Fyock, Willis Towers Watson
Jaclyn Iglesias, Willis Towers Watson
Rebecca Warnken, Willis Towers Watson

Introductions/Sign In

Director Jackson called the meeting to order at 2:00 p.m. Introductions were made and a welcome to the new SEBC committee members.

Approval of Minutes - handout

Director Jackson entertained a motion to approve the minutes from the December 16th SEBC meeting. Controller General Morton made the motion. Mr. Klopp seconded the motion and the motion carried.

Director's Report – Brenda Lakeman, SBO

Onsite Clinic RFI: As mentioned in the strategic plan, Statewide Benefits Office (SBO) will be doing an Onsite Clinic RFI. SBO will be working with Willis Towers Watson (WTW) on the development with potential release in the next four to six weeks.

Transitional Reinsurance Fee: This fee is one of the fees associated with the ACA; the plan just paid the fee for CY2016 for \$2.6M. That is the last of the three years for the transitional reinsurance fee.

SBO Move: The move is complete and the address change has been updated on the website and documents and the Rules & Regulations.

Financial Reporting

November 2016 Fund & Equity Report - handout – Casey Oravez, Financial Operations

An overview of the Fund & Equity (F&E) reporting was presented for the new members which contains the actuals for the month compared to what is budgeted for the month with the year to date total amount compared to the year to date total budget. Premium contributions includes employee share, State share and all other revenues. A glossary is

included for further definition of these categories. Anticipated receipt of the federal reinsurance payment in November did not occur until January for the amount of \$8.8M to be reflected in the January F&E report. This caused the operating revenues to be lower than budgeted. A Medicare Part D Coverage Gap discount of \$3.7M was received. Operating expenses show claims broken down by vendor and shows the fund running under budget which is good. One of the ACA payments was made for the year in the amount of \$1,072.625.00 which was budgeted. The F&E ending balance is \$47.7M compared to the budgeted \$46.4M but to include the federal reinsurance would increase the ending total bringing the ending balance a bit shy of the claim liability target of \$48M and nothing in the minimum reserve.

FY17 Qtr 1 Financial Reporting – handout - Willis Tower Watson (WTW)

Rebecca Warnken presented the FY17 Q1 Cost Analysis with an in-depth view of this reporting to benefit the new committee members. This financial report has two major components. First is the Financial Summary looking at the plan performance, how the plan is running against budget, year over year. Second component is a new element to look at the Key Cost Drivers with an in-depth view of what is happening with member utilization of services and using information pulled from Truven's data dashboard. Ongoing highlights will be provided showing where key changes or key deviations are seen. This data is through September 2016 (1Q FY17) so there is a time lag compared to the F&E report but WTW is working with Finance to assure consistency. Medical and Prescription drug (Rx) results for the 1Q FY17 actual expenses total \$190.5M, 4% under budget with a loss ratio of 96%, resulting in a surplus of \$8.8M for 1Q. Seeing consistent results between this reporting and the F&E. Further details broken out for the active, Non-Medicare retiree and the Medicare eligible populations. Loss ratio is using the budgeted numbers – comparing actual expenses to what was budgeted. Overall medical/Rx costs per employee increased 3.6% from Q1 FY16 to Q1 FY17. If claims continue as currently seen, will be looking at a 5.4% increase year over year which is a bit under the 6% seen on a national basis for trend. Same detail provided broken down by vendor. Ms. Warnken continued with the cost components (utilizes the Truven data) which provides more detail to be tracked each quarter separately with a year to date total and a full year projection. For each quarter, the plan is to focus on the highlights, the Executive Summary and this level of detail is provided as needed. Footnotes were explained. High Cost Claims (HCC) analysis show through September 2016, there are 103 members with claims over \$100K for a total of \$18.8M. This analysis will be updated as members reach the threshold, new ones are added or removed. The Third Party Administrator (TPA) will continue to monitor the HCC's to explore opportunities to engage with care management. It's noted that 100% medical is driving costs versus Rx. The balance of dashboards were presented. WTW to add a total and percentage in #8 Top (10) Medical Conditions (by cost). Cholesterol and breast cancer screenings are above benchmark. Dialogue occurred specifically to dashboard #10 Chronic Conditions which is high relative to the average. Summary of the terminology included. Dashboards with similar data is included for the Early Retirees and Medicare Retirees. This quarterly report ties back to the established benchmarks.

GHIP FY18 Budget Projections - Overview of Pricing Methodology – handout - Willis Tower Watson (WTW)

An overview of the WTW pricing methodology was shared along with the preliminary FY18 projected medical/Rx aggregate budget. This will be refreshed for the February 6 SEBC meeting with another three months of data through December 2016 and updated savings associated with the ESI contract. The three steps in developing the budget are data collection, assumption and pricing analysis and aggregate budget development. The steps were further explained in detail. WTW is conducting an analysis of the ESI contract that may reflect changes in the contract, how that change will impact the claims and any changes in rebate payments. From National survey data, trends are expected to increase 6% on a national basis and 7% for the public sector. A recommended FY18 trend of 6.5% is set for Actives and non-Medicare retirees and a lower 3% trend set for Medicare retirees for medical. Prescription trend continues to run higher than medical driven by specialty spend, setting that at a 10% trend. All fees are built into the budget. FY18 preliminary budget projection of \$781.7M is a 2.0% decrease compared to FY17 or a \$16M decrease. Any reduction in FY18 budget will be used to fund GHIP reserve. The trends used for FY17 were 8.5% medical and 15.7% for Rx which increased premiums by 7+%. FY18 budget to be further refined based on Q2 vendor data and WTW analysis of ESI contract savings. Dialog occurred around the trends and how pharmacy is trending faster and higher than medical.

Healthcare Trend Variability Analysis – handout - Willis Tower Watson (WTW)

Background on the volatility of self-funding projections due to outside factors was presented. Statistical confidence intervals to better quantify and address volatility and risk tolerance concerns were provided along with the financial

projections utilizing data sources noted. Dialogue on volatility, previous year's occurrences and unpredictable elements occurred.

Planning for FY2018 – handout - Willis Tower Watson (WTW)

Kevin Fyock explained the GHIP member decision matrix. Open Enrollment period is when the key decision categories will be relayed to the member with an Active Enrollment to engage members. A decision support tool (myBenefitsMentor®) will guide members to help steer them to the best suited plan.

Ms. Lakeman informed the committee those members whose plans will no longer exist in FY18 will have to make a choice and those whose plans will still exist do not have to make an active election. There is budget epilogue language stating if taking no action is taken to enroll, the member remains in the same plan for the next year. This language will need to be changed for the future since it cannot be changed before May 2017. Communications from SBO will strongly encourage members to use myBenefitsMentor® to make their choices and good participation in the tool is anticipated.

From the mission, highlights of the vision, goals and tactics were created which was approved by the SEBC before 2017. Mr. Fyock took the committee through an exercise outlining the attributes and the key elements. Jaclyn Iglesias guided the committee through a more detailed dive of the exercise to show if aligned with FY18 or future planning and the current direction of the potential future state. Future dialogue with the SEBC may be around the differentiation among the plans, specifically looking at the medical plan price tags driving some enrollment toward consumer directed or value based plans with more opportunities in using data to drive decisions for future plan structure. A lot of good alignment has already been made for July 1, 2017, yet more exists. Dialogue around adding an HSA plan and time needed for legislation followed. Items requiring legislation would be the removal of the First State Basic Plan and Double State Share. The calendar of GHIP tactics for CY2017 and how these tactics could be reviewed by the SEBC on a month to month basis was shared. This is aligned with the different goals established for the GHIP. Each specific tactic is tied back to prior pages noted in the slide deck for a particular attribute.

The default enrollment options and factors impacting the decisions to be made were reviewed. The committee will need to make a default decision for those individuals who no longer have the Highmark CDH or Highmark HMO plans available to them beginning July 1, 2017. The current epilogue only applies to those employees who are enrolled in a plan in the current year and that same plan will remain available in FY18 and the employee chooses to take no action during open enrollment. In regards to the CDH plans, for individuals in these plans who move from one vendor to another, if they have health reimbursement dollars remaining at the end of the year, those funds roll over and carry with them from vendor to vendor. If the employee elects or is defaulted to a non-CDH plan, the employee will lose any carry over or remaining health reimbursement dollars.

Group Health Program FY18 Planning and Governor's Recommended Budget Proposal

FY18 SEBC Planning Meetings - handout – Brenda Lakeman, SBO

As the FY17 Q1 financials were reviewed at today's meeting, the FY17 Q2 financials will be reviewed at the next meeting with the December Fund Equity which allows for budget projections for FY18. Any plan design option changes as well as the default options for SEBC to consider will be presented at the next meeting. The next three SEBC meetings and the objectives of those meetings were presented. Dialogue around collecting the data, building up the reserve, and premium increases occurred.

Health Plan Changes in Governor's Recommended Budget – handout – Brenda Lakeman, SBO

Changes were presented as noted in the handout. Concern around the first two options was expressed and if SEBC should provide a statement to the legislature. Savings from the first two options were calculated from WTW where the last two options were carried over from last year. Option one would have an implementation of January 1, 2018 (6 month savings) with a savings of \$3.3M general fund and option two would have \$15.2M general fund savings in FY18.

2017 Open Enrollment Updates – handout – Faith Rentz, SBO

Overview of the challenge at hand and the State of Delaware's and SEBC's commitment was shared. Consumerism efforts continue as launched in 2016 to add and enhance resources on the website that has had more than 54,000 web

page views showing the success and interest from the participants. Initiatives to drive change include Consumer Online Course launched September 2016 with 16,000 employees completing the course. Discussion ensued around the low School District employee participation rate in the Consumerism course. Continued initiatives include the use of Truven's myBenefitsMentor® Consumer Decision tool, active enrollment in May 2017 and the detail of the Medical TPA's contracts awarded in December 2016. Planning for April 2017 to assign mini-trainings/videos and launch an online Interactive Open Enrollment Guide and the myBenefitsMentor® tool with targeted letters. Open Enrollment dates will be in phased in three separate time periods as shown in the handout for an active enrollment and to reduce volume in the Employee Self-Service. Meeting dates for the Benefit Representatives, Employee Education Sessions and Health Fairs were shared.

Group Health Program Cost Control and Program Integrity Review – Faith Rentz, SBO

In March 2016, SEBC awarded the contract for medical claim audit services for both medical and prescription to Claim Technologies and TriCast to conduct a comprehensive review of medical and prescription claims administration for the period of review July 1, 2013 thru June 30, 2015 for the medical plans and for the actives and non-Medicare prescription plan. For the Medicare prescription plan, the audit review was January 1, 2014 through December 31, 2015. No findings or recommendations resulted from the ESI review. Highmark and Aetna had few significant findings and the targeted claims review focused on specific areas such as duplicate claims, plan limitations, non-emergency use of the ER and clinical review process of radiology and high-tech imaging.

Public Comments

None

Other Business

None

Motions

None

Ms. Lakeman announced the committee will be moving into Executive Session and return to public session with no other business to address and requested a motion to move into Executive Session. Mr. Klopp made the motion and Controller General Morton seconded the motion. Motion carried and Committee entered into Executive Session at 4:17 pm.

The Committee returned to public session where the Director asked for a motion to adjourn the meeting. Mr. Klopp made the motion and Controller General Morton seconded the motion and the meeting adjourned at 4:30 pm.

Respectfully submitted,

Lisa Porter
Statewide Benefits Office